

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/13/2014
NAME OF PROVIDER OR SUPPLIER ST VINCENT CARMEL HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 13500 N MERIDIAN ST CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Complaint Number: IN00133567 Substantiated: No deficiencies related to the allegations are cited.</p> <p>Facility Number: 003932</p> <p>Date of Survey: 01/13/2014</p> <p>Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>St. Vincent Carmel Hospital, Inc. is in compliance with 410 IAC 15-1.6-.2, Emergency services, Hospital Licensure Rules.</p> <p>QA: cloughlin 02/03/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE